SOUTH DAKOTA
CARDIOVASCULAR
COLLABORATIVE

2022 Cardiovascular Collaborative Mid-Year Meeting

February 25, 2022 - 1:00 - 2:30 PM CT

WELCOME TO THE 2022 CARDIOVASCULAR COLLABORATIVE MID-YEAR MEETING

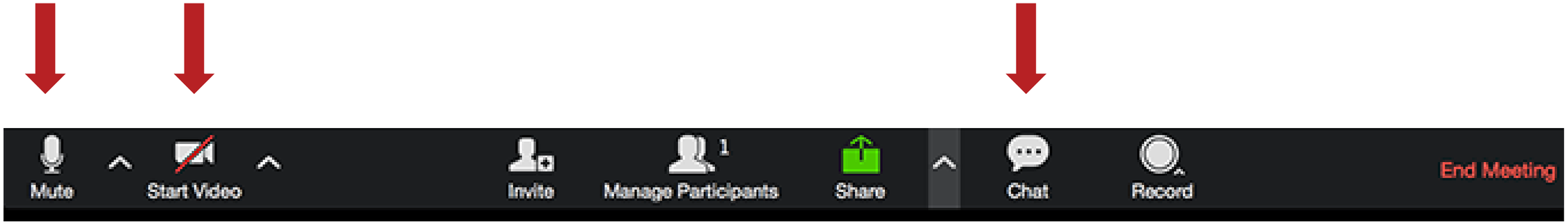
Chrissy Meyer, MBA
Communications Director
American Heart Association

TODAY'S AGENDA

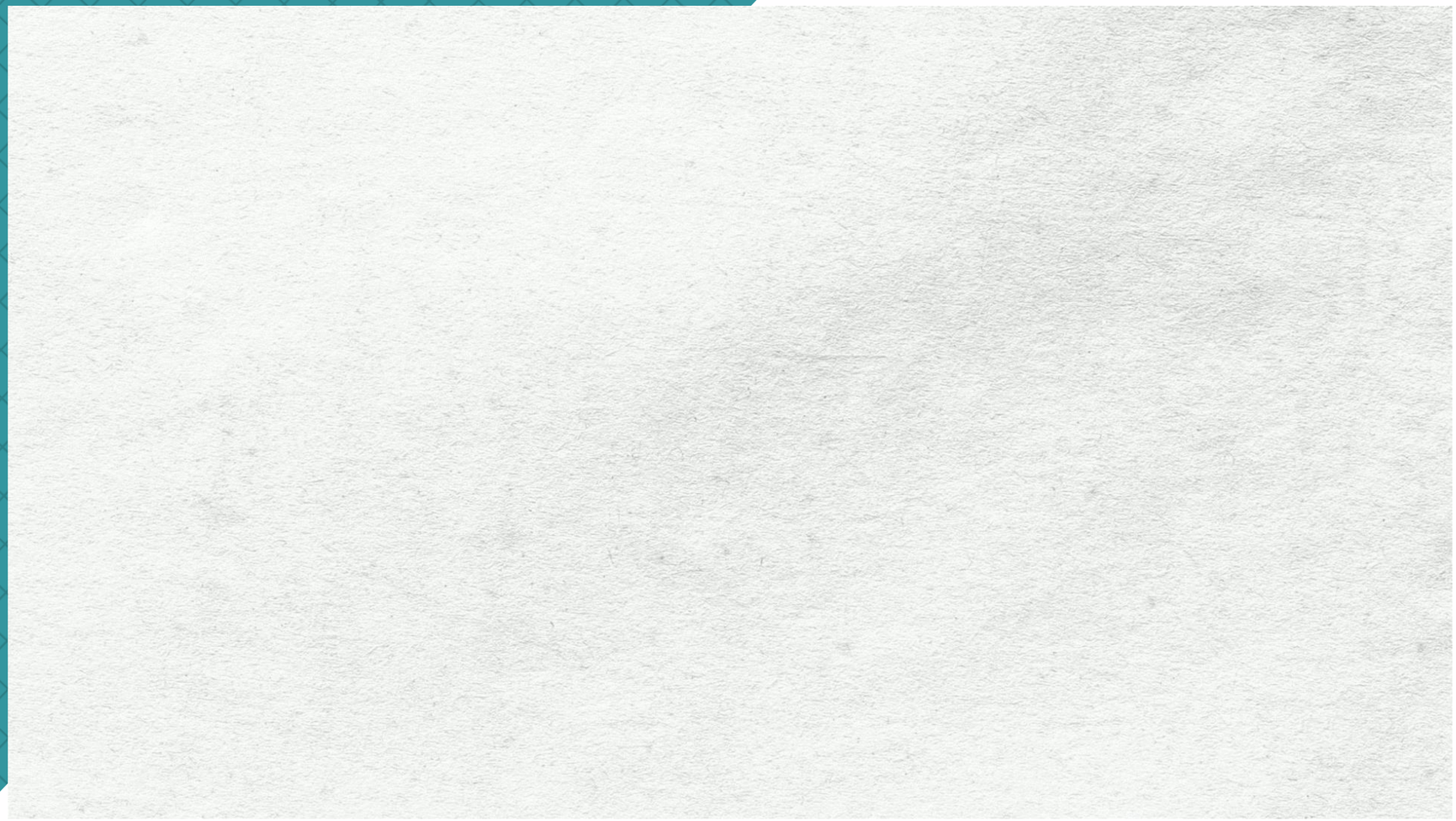
- Announcements
- The Role of Pharmacists in Cardiovascular Disease Prevention and Management
- Update on 2022-2026 Strategic Plan
- Closing

Housekeeping: Mute/Unmute

Please mute your audio
Cameras off
Questions at any time in chat box
Meeting will be recorded
Participation encouraged :)



NATIONAL WEAR RED DAY RECAP



SUBMIT A SUCCESS STORY!

We want to hear about what other Collaborative members are working on, share accomplishments, and share lessons learned with one another. We would love to hear from you, whether it is a success big or small. We will be **featuring a new success story in each newsletter**, so be sure to submit one to be featured!

For more information or to submit a success story, please email Rachel Sehr.

PRESENTED BY:
DR. SHARREL PINTO
AND DR. DEIDRA VAN GILDER OF SOUTH DAKOTA STATE UNIVERSITY

The Role of Pharmacists in Cardiovascular Disease Prevention and Management

THE ROLE OF PHARMACISTS IN CARDIOVASCULAR DISEASE PREVENTION AND MANAGEMENT

Dr. Sharrel Pinto

Department Head | Allied and Population Health
Hoch Endowed Professor for Community Pharmacy Practice
Director | Community Practice Innovation Center (CPIC)
Email: sharrel.pinto@sdstate.edu

Dr. Deidra VanGilder

Associate Professor| Pharmacy Practice
Ambulatory Care Pharmacist at the Brown Clinic
Core Faculty| Community Practice Innovation Center (CPIC)
Email: deidra.vangilder@sdstate.edu

South Dakota State University
College of Pharmacy and Allied Health Professions

South Dakota Department of Health

South Dakota Heart Disease & Stroke Prevention Program

South Dakota DP Diabetes Program

LEARNING OBJECTIVES

Describe methods to identify care gaps within their communities.

Identify different stakeholders impacting patient care and their specific interests.

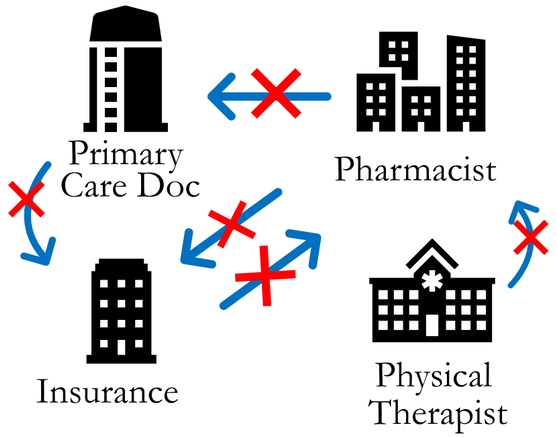
Discuss strategies for working with pharmacy partners.

1. WHICH OF THE FOLLOWING ARE KEY HEALTH CARE PARTNERS IN YOUR COMMUNITY? CHECK ALL THAT APPLY.

2. WHAT SERVICES ARE PROVIDED BY PHARMACISTS IN OUR STATE? CHECK ALL THAT APPLY.

3. WHAT CHALLENGES DO YOU FACE IN YOUR CURRENT ROLES THAT A PHARMACISTS COULD ALLEVIATE? CHECK ALL THAT APPLY.

HEALTH SYSTEM CHALLENGES



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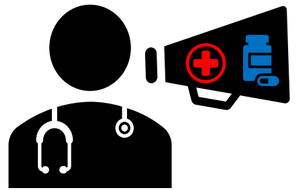
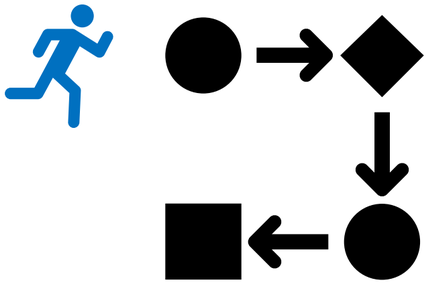
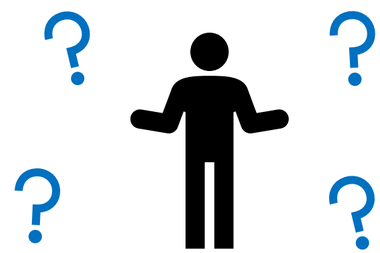






VALUE-BASED CARE PERFORMANCE INDICATORS OUTCOMES

DRUGS DON’T WORK IN PATIENTS WHO DON’T TAKE THEM!

-C. EVERETT KOPP

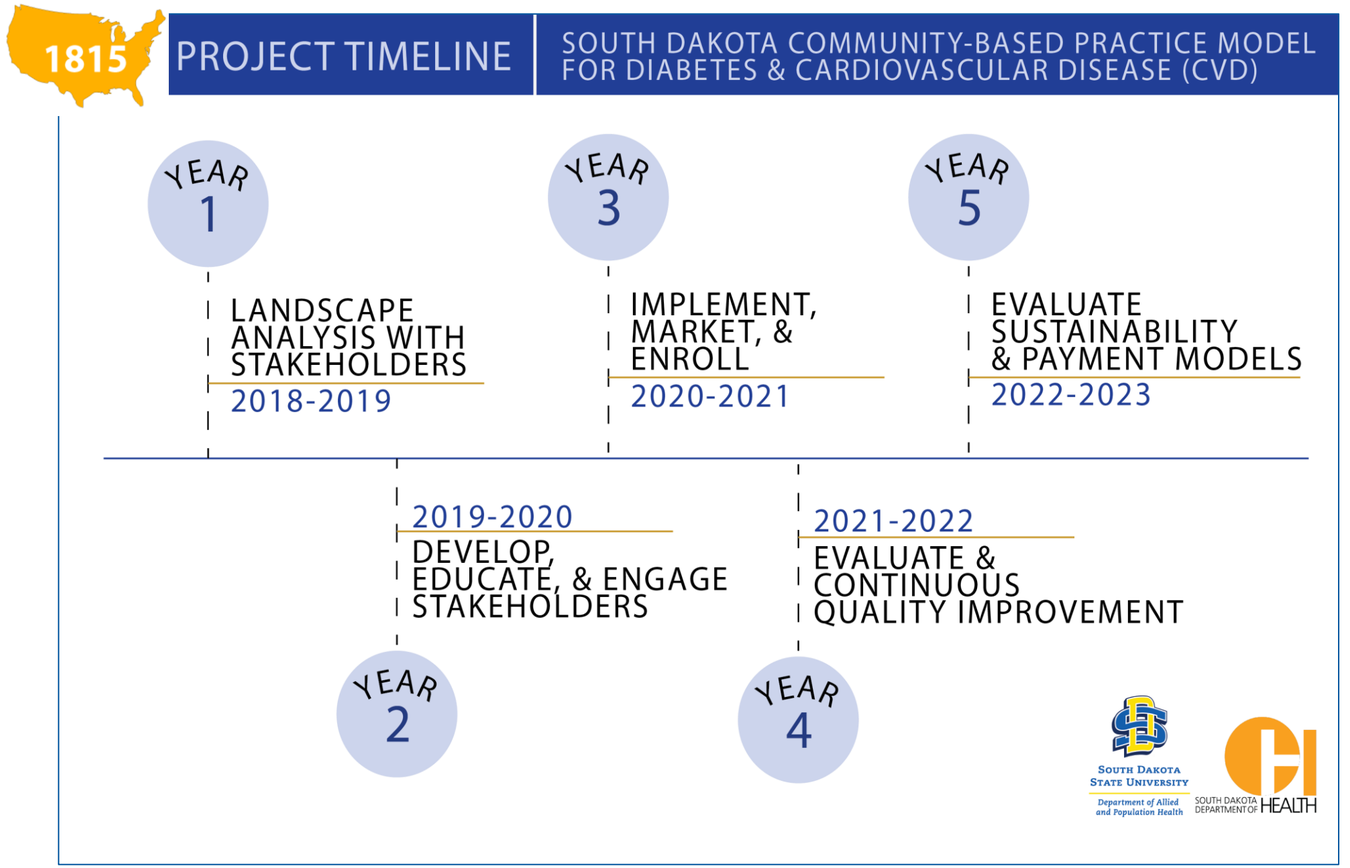
IDENTIFYING CARE GAPS

Review	Review your landscape
Think	Think outside the box, but don't forget currently established pathways and collaborations
Center	Center the process around the patient
Intertwine	Intertwine your investigative process with the 3 Ps • Patients, Practitioners, Payers
State	State Departments of Health are often an under-utilized resource for forging pharmacy partnerships

CDC 1815: THE PLAN

1. *Increase engagement of pharmacists in the provision of medication management.*
2. *Promote the adoption of MTM between pharmacists and physicians.*

PROJECT OVERVIEW



LANDSCAPE ANALYSIS STRATEGY

Three Stakeholder Groups

Patients

Practitioners

Payers

Elicitation Interview

(90 minutes)

Focus Group

(3 hours)

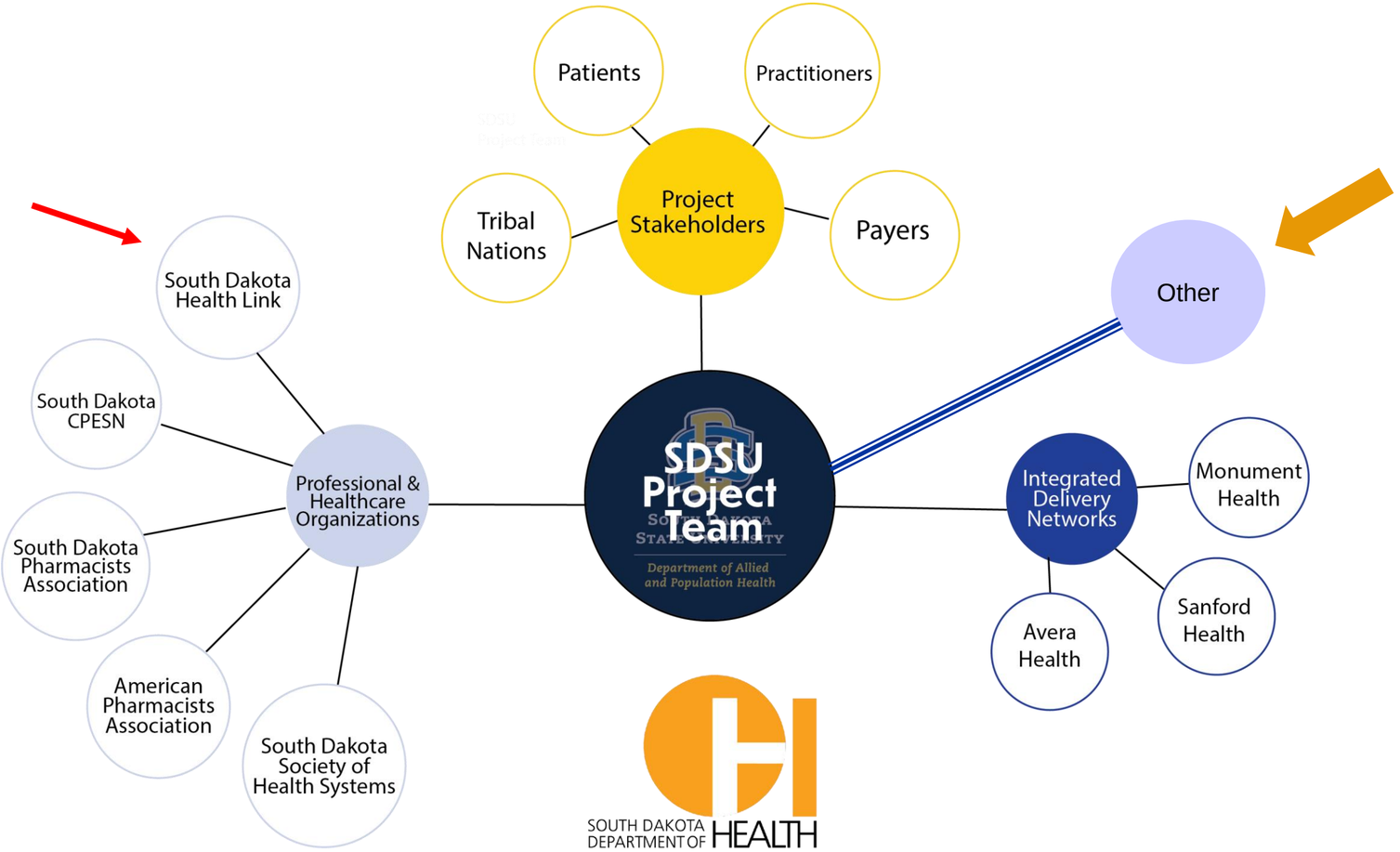
Data Collection

Goal

To assess *needs* and community *assets*.

PARTNER ENGAGEMENT

PARTNER ENGAGEMENT



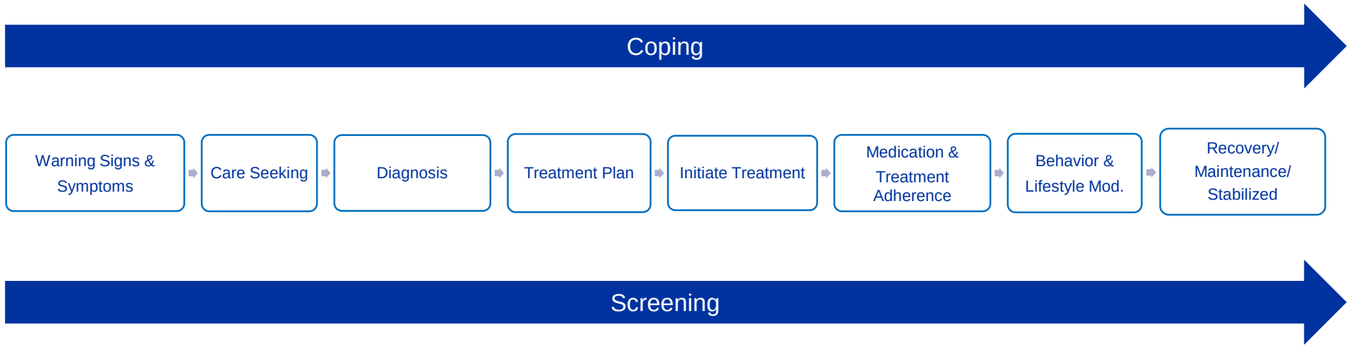
Examples of "Other" Organizations

1. Federally Qualified Health Care Centers (FQHCS)
2. South Dakota Urban Indian Health
3. State Medicaid and Home Health Care
4. Regional Pharmacy Chains: e.g. Lewis Drug
5. Independent Pharmacies

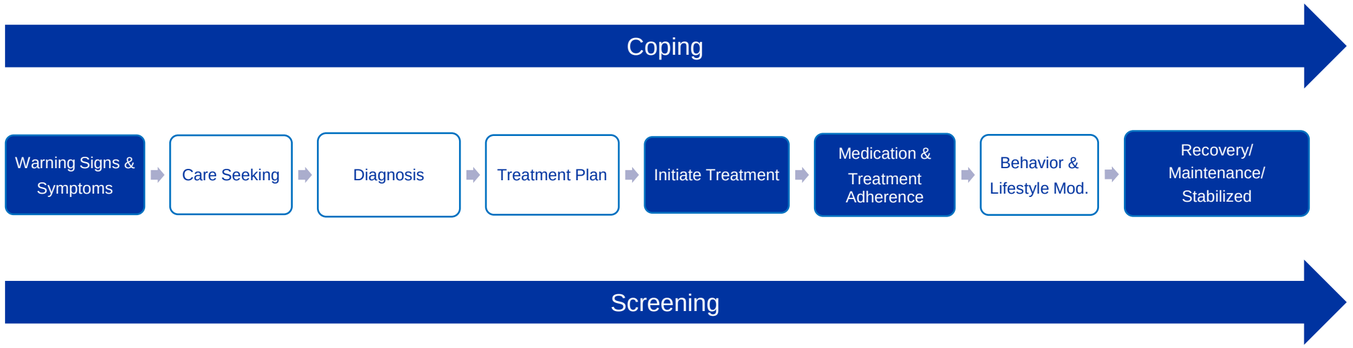
GAPS - NEEDS - PARTNER ENGAGEMENT- STRATEGIES

PATIENTS

PATIENT GROUP: HEALTHCARE JOURNEY



PATIENT GROUP: HEALTHCARE JOURNEY



"The doctor tells you to do something, well if it costs me any money I'm not really interested."

"We were doing great when we joined the Better Choices Better Health Program. When that stopped, we went back to bad habits."

"I wish I had talked more with my doctor about what I was feeling. Thankfully, I said something to K *(Pharmacist)* and he told me to go in."

"I haven't told my family that I have this disease…going on 7 years now. It's too shameful and I'm embarrassed."

"We haven't been able to see our doctors for months. I know I've had this for a while but it would be good to check in with someone."

PRACTITIONERS

PRACTITIONER GROUP: CHALLENGES

- Understanding of MTM
- Using practitioners to schedule appointments
- Financial barriers for patients
- Lack of facility space
- Staff turnover
- Lack of time
- Attempt to improve provider referrals to MTM pharmacy services
- Patients don’t see value in diabetes education
- Patient transportation
- Proximity to other providers

“Um people have larger deductibles, not all of them understand that, um but it seems like they have larger deductibles and they’re just not willing to do out of pocket.”

-Certified Diabetes Educator

“I haven’t heard about MTM, but it would be amazing if they *(my patients)* could get this service. Gosh, I wish I could consult with the pharmacist for questions I get asked and have to look up ”

-RN, CDE

“Docs love it when we do the prior auths *(authorizations)* for them. It saves them time Plus it opens up a conversation for other services like making recommendations or titrating doses.”

-Pharmacist

“ Counseling space is always an issue in the pharmacy, but we just pick up the phone and call the patient or their family. We don’t let space stop us from helping our patients .”

-Pharmacist

“I don’t have a ton of time with my patients, which is a shame. I can’t tell you how often I’ve wanted a pharmacist on speed dial.”

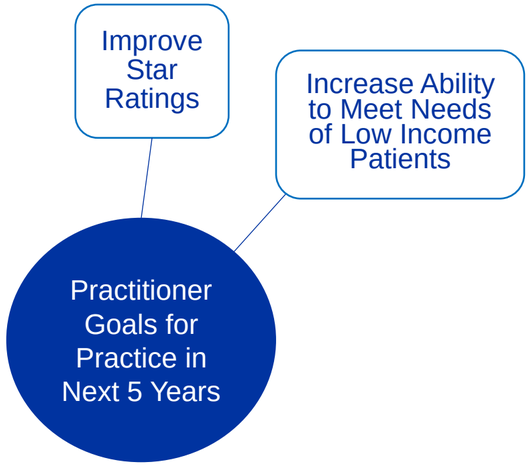
-Provider

“We use our pharmacist all the on rounds. I wish I had the same access in clinic. It would cut down on so much of my time and stress.”

-APP

BUILDING GOALS AND STRATEGIES

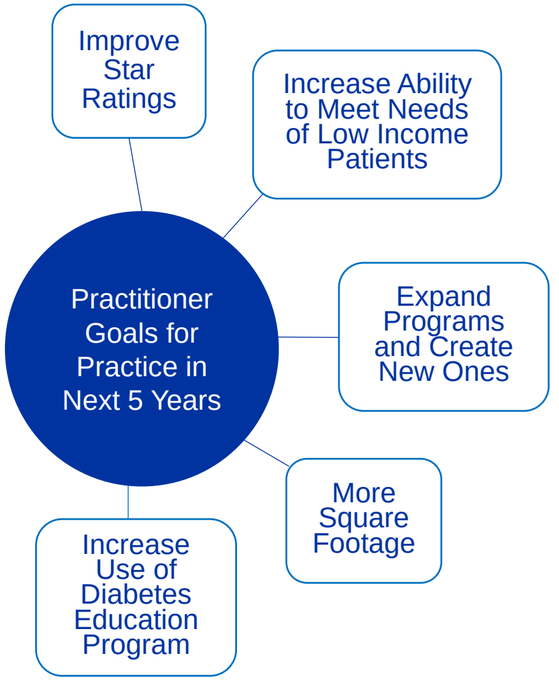
PRACTITIONER GOALS AND STRATERGIES



“One time I didn’t have money to get my blood pressure pills so I was waiting a week until I could get my check I went to [name of pharmacy] and the guy told me I should go to the hospital because my blood pressure was so high.”

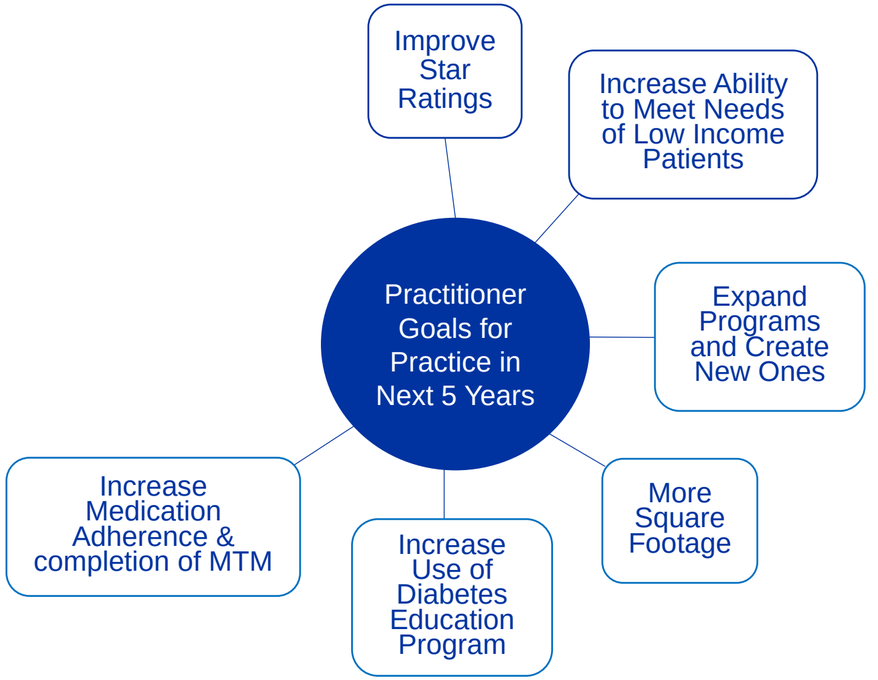
-Patient

PRACTITIONER GOALS AND STRATERGIES



“I think it would be great in the beginning of any diagnosis. If you were told how to manage [diabetes] and to help you manage.”
-Patient

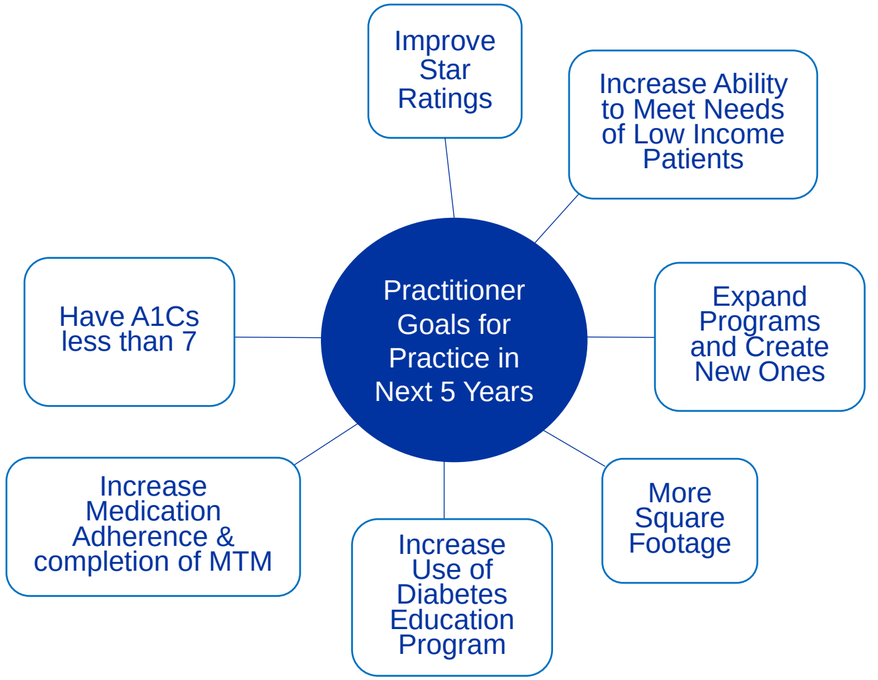
PRACTITIONER GOALS AND STRATERGIES



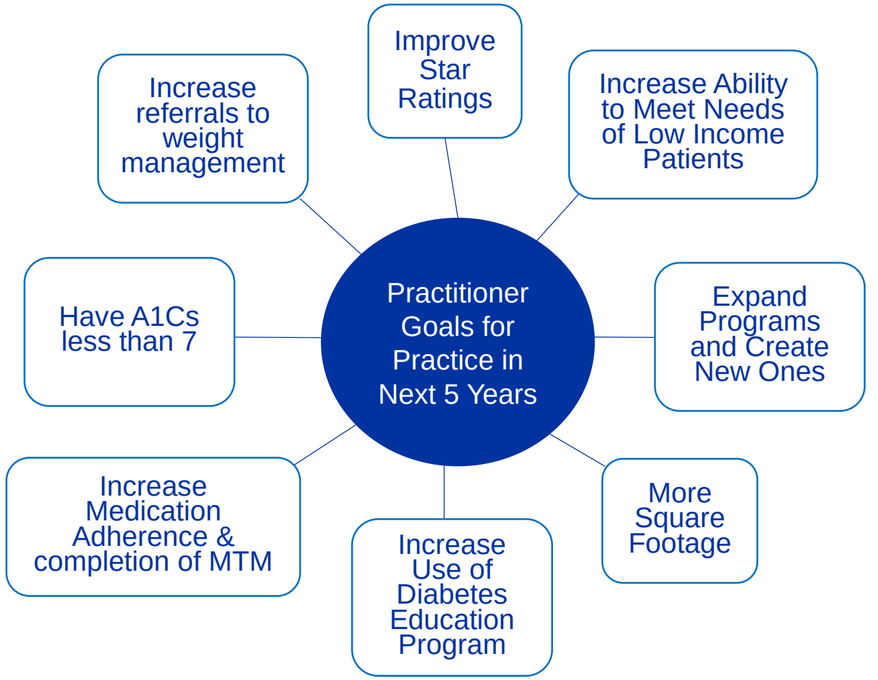
“Like, what does Metformin do? What does Glipizide do? Which one should I be cutting back or, you know, I don’t really know they act, you know what I mean? I could be much more educated on that.”

-Patient

PRACTITIONER GOALS AND STRATERGIES



PRACTITIONER GOALS AND STRATERGIES



PAYERS

PAYER GROUP

- Participants included representatives from three private health plans of large regional/international Integrated Delivery Networks
- Vast experience in the field, including high-level executives
- Various departments represented
  - Plan Structure and Integrity
  - Provider Contracting and Engagement
  - Population Health Services
  - Care Coordination
- None of the payers interviewed, at the time, reimbursed for pharmacist-based services

“I'm not sure that the health system or even the health plan fully understands it in full transparency right now.”

“…if I’m sending them a five-page report and there’s really just one element of information…buried on the third page…chances are they’re not going to get the information they need.”

“Traditionally, this has been the role of only the physician. This isn’t working. Pharmacists could take the burden off providers, allowing them more time to provide valuable patient visits.”

PAYER/OTHERS GROUP: INCORPORATING PHARMACISTS

> “Traditionally, this has been the role of only the physician. This isn’t working. Pharmacists could take the burden off of providers, allowing them more time to provide valuable patient visits.”

PAYER/OTHERS GROUP: CHALLENGES

PAYER GOALS AND STRATERGIES

Relationship-building
Years 1 & 2

- Connect with regional health plan leaders to understand their process, concerns, and goals for reimbursing pharmacy-based services

Engagement
Years 1 & 2

- Invite health plan representatives to participate in project programs and activities
- Discuss mutual goals and plans between organizations through regular, consistent follow-up meetings

Continued Collaboration
Years 2 -5

- Share findings from ongoing projects
- Provide resources to aid in the development of policies for pharmacy-based reimbursement
- Tailor forms, policies, and trainings to best assist regional health plans

WHAT'S IN IT FOR *YOU*?

EMPOWERING PATIENTS

ENHANCING PRACTITIONER/EMPLOYEE WELL-BEING

ENGAGING PAYERS

DECREASED STAFF TURNOVER

IMPROVED PATIENT HEALTH OUTCOMES

INCREASED JOB SATISFACTION

SERVICES PHARMACISTS CAN PROVIDE

- Community/Retail: MTM, Immunization, Medication Adherence, Prior Authorizations
- Ambulatory Care/Clinic Pharmacist: Disease State Management (DSM), Education, Medication Reconciliation, Transitions of Care (TCM), Chronic Care Management (CCM)
- Hospital Pharmacist: TCM, DSM, Education, Med Reconciliation, Discharge Counseling
- Long Term Care: DSM, Care coordination, Prior Authorization
- Other Opportunities

BEST PRACTICES WHEN WORKING WITH PHARMACIES/PHARMACISTS AND COMMUNITY PARTNERS

Build on existing relationships and don't hesitate to pick up the phone and call people

Academia and State Organizations can be a resource

Understand the structure of the organization and their priorities

Align priorities with current or future work plans

You may need to work from the ground up, start with a smaller department and build your network from within

Build the bridge and breakdown silos

REFLECTION QUESTIONS

- What experiences have you had:
  - Working with SDSU
  - Engaging in collaborations with pharmacists
  - Developing programs across your communities
  - If you were to begin, what would be your biggest challenge and how would you plan to overcome it

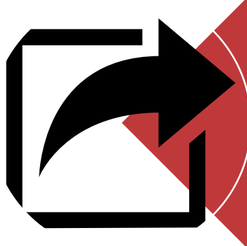
SESSION OBJECTIVES

1. Describe methods to identify care gaps within their communities.
2. Identify different stakeholders impacting patient care and their specific interests.
3. Discuss strategies for working with pharmacy partners.

PRESENTED BY:
SARAH ANDERSON-FIORE OF EMORY CENTERS

Update on the 2022-2026 Strategic Plan

Today’s Goals



Share progress on Strategic Plan

Give opportunity for feedback

Discuss next steps

Strategic Planning Process

Approach to Strategic Planning

- Shared ownership of state plan
- High impact and evidence-based
- Realistic, achievable goals
- Consensus = 80% comfortable - “I can live with this”

Scully!

A strategic plan includes:	
Vision *“Aim for This”*	A picture of the “preferred future”: A statement that describes how the future will look like if the organization achieves its ultimate aims.
Mission *“Talk About This”*	A statement of the overall purpose – describes what you do, for whom you do it, and the benefit
Goals *“Focus on These”*	Broad, long-term aims that define accomplishment of the mission
Objectives *“Measure These”*	Specific, quantifiable, realistic targets that measure the accomplishment of each of your goals over a specified period of time
Strategies *“Work on These”*	Broad activities required to achieve an objective
Activities *“Do These Things”*	Specific steps to be taken, by whom, to implement a strategy

South Dakota Cardiovascular Collaborative Strategic Plan, 2022-2026

DRAFT as of 2/25/22

VISION: Healthy people, healthy communities, healthy South Dakota
MISSION: To improve quality of life for all through prevention and management of cardiovascular disease and associated risk factors

PRIORITY POPULATIONS: Native Americans, people living in rural areas, people with lower incomes

Goals Focus On	I. Advance health equity in prevention, treatment, and management of cardiovascular disease	II. Optimize health through prevention of chronic diseases	III. Improve response to acute cardiovascular incidents	IV. Support cardiovascular disease management
Objectives Measure	1. Maintain or decrease the mortality rate from heart disease among Native Americans at 258.3 per 100,000 2. Decrease the percentage of adults with an income of less than $25,000 who have ever been diagnosed with heart attack from 6.4% to 5% 3. Increase the percentage of adults with an income of less than $25,000 who report having a health care provider from 74.8% to 77% *4. TBD objective re: people in rural areas* 5. Increase the percentage of patients who reported that their doctor "always" explained things in a way they could understand from 82% to 85%	1. Maintain the percentage of adults classified as having a normal weight by BMI at 29.8%. 2. Increase the percentage of adults who meet physical activity guidelines of 150 minutes or more per week from 45.7% to 48%. 3. Decrease the percentage of adults who currently use commercial tobacco from 27.8% to 26%. 4. Increase the percentage of adults who report visiting their doctor for a routine checkup within the last year from 74.2% to 77%.	1. Decrease ambulance chute times from 3.9 minutes to 3.25 minutes. 2. Increase the number of Cardiac Ready Communities from 1 to 5. 3. Increase the number of EMTs from 3132 to 3850 4. Decrease the mortality rate due to stroke from 35.4 per 100,000 to 33.5 per 100,000. 5. Decrease the mortality rate due to heart disease from 155.1 per 100,000 to 153 per 100,000.	1. Increase the number of participants who complete Better Choices, Better Health SD from 460 to 560. 2. Increase the percentage of adults with high blood pressure who regularly check their blood pressure from 63% to 65% 3. Maintain or decrease the percentage of adults who have ever been diagnosed with a heart attack at 3.5%. 4. Maintain or decrease the percentage of adults who have ever been diagnosed with stroke at 2.2%.
Strategies Work On	A. Collaborate with communities and priority populations to identify and address needs related to cardiovascular health B. Promote equitable access to prevention, treatment, and management programs and resources C. Enhance partners' organizational capacity to promote health equity across sectors	A. Promote increased physical activity across the lifespan B. Promote healthy food and beverage consumption C. Promote commercial tobacco cessation D. Encourage annual preventive care visits and screenings E. Support healthcare professionals in counseling patients about risk factors and making referrals to prevention programs F. Support implementation of K-12 holistic health education programs	A. Strengthen the active EMS workforce B. Promote adoption of the Cardiac Ready Community program C. Promote continuity and collaboration of care at each point of the chain of survival D. Bolster review and utilization of cardiovascular data E. Promote utilization of the latest cardiac and stroke guidelines	A. Support referral of adults with cardiovascular disease to management programs and resources B. Promote utilization and support pharmacist-provided services, including medication therapy management C. Support expansion of the CHW profession D. Maximize community-clinical linkages

CORE PRINCIPLES

Emphasize health equity | Engage partners and communities | Collaborate across sectors and chronic disease programs | Endorse holistic health promotion | Use evidenced-based strategies

Goal I : Advance health equity in prevention, treatment, and management of cardiovascular disease

OBJECTIVES – what we're measuring

1. Maintain or decrease the mortality rate from heart disease among Native Americans at 258.3 per 100,000.
2. Decrease the percentage of adults with an income of less than $25,000 who have ever been diagnosed with heart attack from 6.4% to 5%.
3. Increase the percentage of adults with an income of less than $25,000 who report having a health care provider from 74.8% to 77%.
4. Rural population objective is TBD.
5. Increase the percentage of patients who reported that their doctors "always" explained things in a way they could understand from 82% to 85%.

STRATEGIES – what we're working on

A. Collaborate with communities and priority populations to identify and address needs related to cardiovascular health

B. Promote equitable access to prevention, treatment, and management programs and resources

C. Enhance partners' organizational capacity to promote health equity across sectors

Goal I Clarifying Questions & Feedback

Use the **Chat Box to ask questions** about this Goal

Use the **Poll to share your overall impression** of the plan for this Goal

Goal II: Optimize health through prevention of chronic diseases

OBJECTIVES – what we're measuring

1. Maintain or increase the percentage of adults classified as having a normal weight by BMI at 29.8%.
2. Increase the percentage of adults who meet physical activity guidelines of 150 minutes or more per week from 45.7% to 48%.
3. Decrease the percentage of adults who currently use tobacco from 26% to 23%.
4. Decrease the percentage of adults who have been told they have high blood pressure from 27.8% to 26%.
5. Increase the percentage of adults who report visiting their doctor for a routine checkup within the last year from 74.2% to 77%.

STRATEGIES – what we're working on

A. Promote increased physical activity across the lifespan

B. Promote healthy food and beverage consumption

C. Promote commercial tobacco cessation

D. Encourage annual preventive care visits and screenings

E. Support healthcare professionals in counseling patients about risk factors and making referrals to prevention programs

F. Support implementation of K-12 holistic health education programs

Goal II Clarifying Questions & Feedback

Use the **Chat Box to ask questions** about this Goal

Use the **Poll to share your overall impression** of the plan for this Goal

Goal III: Improve response to acute cardiovascular incidents

OBJECTIVES – what we're measuring

1. Decrease ambulance chute times from 3.9 minutes to 3.25 minutes.
2. Increase the number of Cardiac Ready Communities from 1 to 5.
3. Increase the number of EMTs from 3132 to 3850.
4. Decrease the mortality rate due to stroke from 35.4 per 100,000 to 33.5 per 100,000.
5. Decrease the mortality rate due to heart disease from 155.1 per 100,000 to 153 per 100,000.

STRATEGIES – what we're working on

A. Strengthen the active EMS workforce

B. Promote adoption of the Cardiac Ready Community Program

C. Promote continuity and collaboration of care at each point of the chain of survival

D. Bolster review and utilization of cardiovascular data

E. Promote utilization of the latest cardiac and stroke guidelines

Goal III Clarifying Questions & Feedback

Use the **Chat Box to ask questions** about this Goal

Use the **Poll to share your overall impression** of the plan for this Goal

Goal IV: Support cardiovascular disease management

OBJECTIVES – what we're measuring

1. Increase the number of participants who complete Better Choices, Better Health SD from 460 to 560
2. Increase the percentage of adults with **high blood pressure** who regularly check their blood pressure from 63% to 65%.
3. Maintain or decrease the percentage of adults who have ever been diagnosed with a heart attack at 3.5%.
4. Maintain or decrease the percentage of adults who have ever been diagnosed with stroke at 2.2%.

STRATEGIES – what we're working on

A. Support referral of adults with cardiovascular disease to management programs and resources
B. Promote utilization and provide support of pharmacist-provided services, including medication therapy management
C. Support expansion of the CHW profession
D. Maximize community-clinical linkages

Goal IV Clarifying Questions & Feedback

Use the **Chat Box to ask questions** about this Goal

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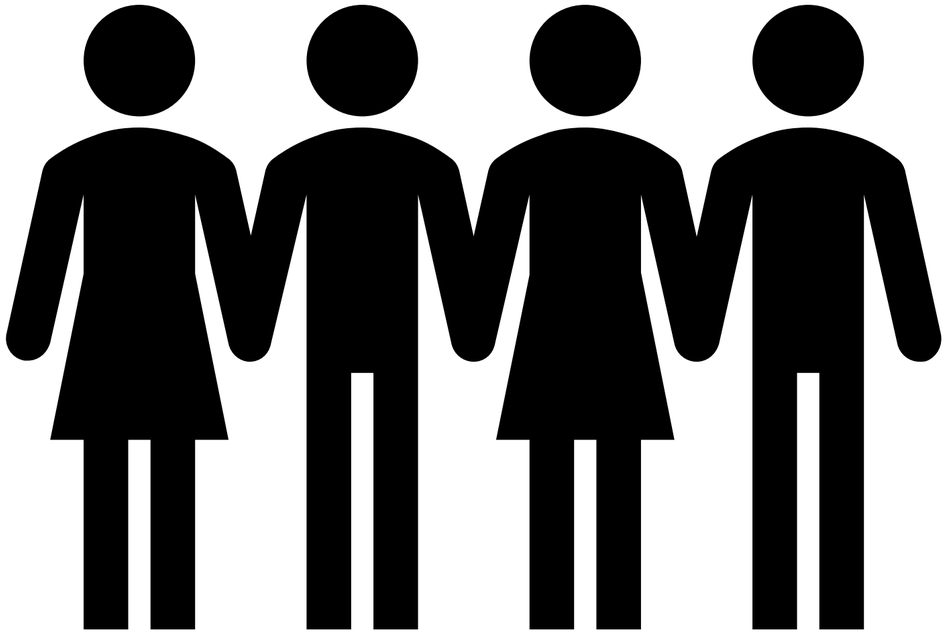
Where do we fit in?



I. Advance health equity in prevention, treatment, and management of cardiovascular disease

A. Collaborate with communities and priority populations to identify and address needs related to cardiovascular health

B. Promote equitable access to prevention, treatment, and management programs and resources

C. Enhance partners' organizational capacity to promote health equity across sectors

II. Optimize health through prevention of chronic diseases

A. Promote increased physical activity across the lifespan

B. Promote healthy food and beverage consumption

C. Promote **commercial** tobacco cessation

D. Encourage annual preventive care visits and screenings

E. Support healthcare professionals in counseling patients about risk factors and making referrals to prevention programs

F. Support implementation of K-12 holistic health education programs

III. Improve response to acute cardiovascular incidents

A. Strengthen the active EMS workforce

B. Promote adoption of the Cardiac Ready Community program

C. Promote continuity and collaboration of care at each point of the chain of survival

D. Bolster review and utilization of cardiovascular data

E. Promote utilization of the latest cardiac and stroke guidelines

IV. Support cardiovascular disease management

A. Support referral of adults with cardiovascular disease to management programs and resources

B. Promote utilization **and provide support of** pharmacist-provided services, including medication therapy management

C. Support expansion of the CHW profession

D. Maximize community-clinical linkages

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Goals Focus On	I. Advance health equity in prevention, treatment, and management of cardiovascular disease	II. Optimize health through prevention of chronic diseases	III. Improve response to acute cardiovascular incidents	IV. Support cardiovascular disease management
Objectives Measure	1. Maintain or decrease the mortality rate from heart disease among American Indians at 258.3 per 100,000 2. Decrease the percentage of adults with an income of less than $25,000 who have ever been diagnosed with heart attack from 6.4% to 5% 3. Increase the percentage of adults with an income of less than $25,000 who report having a health care provider from 74.8% to 77% 4. TBD objective re: rural population 5. Increase the percentage of patients who reported that their doctor "always" explained things in a way they could understand from 82% to 85%	1. Maintain the percentage of adults classified as having a normal weight by BMI at 29.8%. 2. Increase the percentage of adults who meet physical activity guidelines of 150 minutes or more per week from 45.7% to 48%. 3. Decrease the percentage of adults who currently **use commercial tobacco** from 27.8% to 26%. 4. Increase the percentage of adults who report visiting their doctor for a routine checkup within the last year from 74.2% to 77%.	1. Decrease ambulance chute times from 3.9 minutes to 3.25 minutes. 2. Increase the number of Cardiac Ready Communities from 1 to 5. 3. Increase the number of EMTs from 3132 to 3850 4. Decrease the mortality rate due to **stroke** from 35.4 per 100,000 to 33.5 per 100,000. 5. Decrease the mortality rate due to **heart disease** from 155.1 per 100,000 to 153 per 100,000.	1. Increase the number of participants who complete Better Choices, Better Health SD from 460 to 560. 2. Increase the percentage of adults with **high blood pressure** who regularly check their blood pressure from 63% to 65% 3. Maintain or decrease the percentage of adults who have ever been diagnosed with a heart attack at 3.5%. 4. Maintain or decrease the percentage of adults who have ever been diagnosed with stroke at 2.2%.
Strategies Work On	A. Collaborate with communities and priority populations to identify and address needs related to cardiovascular health B. Promote equitable access to prevention, treatment, and management programs and resources C. Enhance partners' organizational capacity to promote health equity across sectors	A. Promote increased physical activity across the lifespan B. Promote healthy food and beverage consumption C. Promote commercial tobacco cessation D. Encourage annual preventive care visits and screenings E. Support healthcare professionals in counseling patients about risk factors and making referrals to prevention programs F. Support implementation of K-12 holistic health education programs	A. Strengthen the active EMS workforce B. Promote adoption of the Cardiac Ready Community program C. Promote continuity and collaboration of care at each point of the chain of survival D. Bolster review and utilization of cardiovascular data E. Promote utilization of the latest cardiac and stroke guidelines	A. Support referral of adults with cardiovascular disease to management programs and resources B. Promote utilization and support pharmacist-provided services, including medication therapy management C. Support expansion of the CHW profession D. Maximize community-clinical linkages

CORE PRINCIPLES

Emphasize health equity | Engage partners and communities | Collaborate across sectors and chronic disease programs | Endorse holistic health promotion | Use evidenced-based strategies


thank
you

2017-2021 Strategic Plan Progress Report

This five-year progress report was recently released and highlights the formation and function of the Collaborative, examines the progress made on the previous strategic plan, reviews key goal area accomplishments, and describes a few lessons learned over this period and the ways the Collaborative is looking ahead.

Review the report and see what we've accomplished: https://doh.sd.gov/documents/diseases/chronic/CC_ProgressReport_2017-2021.pdf

2022 Cardiovascular Collaborative Kickoff Meeting

Tuesday, May 3rd and
Wednesday, May 4th

THANK YOU FOR JOINING US TODAY!

Please fill out the evaluation survey!